DEPARTMENT OF CORRECTIONS
MULTIPLE INMATE REQUEST FOR DISBURSEMENT

PAYEE: _____
NAME

_____
STREET ADDRESS

_____
CITY, STATE & ZIP

Name (Printed)	ODOC #	Name (Signature)	Amount	Date

INMATE REQUEST APPROVED BY:_____ _____
Staff Signature Date

_____ _____ _____ _____
Trust Fund Officer Signature Date Cashier Signature Date

If check is to be returned to the facility _____
Print Department, Position, or Name check is to be returned to

This disbursement may only be used if more than five inmates are participating. Number of pages attached_____

DOC 120230C
(R 11/21)